

United States Bankruptcy Court
61288, Houston TX 77208SOUTHERN DISTRICT OF TEXAS P.O.Box
(Houston Division)

PROOF OF CLAIM

Name of Debtors

☒ Stage Stores, Inc., a Delaware corporation
☐ Specialty Retailers, Inc., a Texas corporation
☐ Specialty Retailers, Inc. (NV), a Nevada corporation

*place an "x" beside the name of the Debtor you are filing a claim against

Case Number

00-35078-H2-11
 00-35079-H2-11
 00-35080-H2-11

Creditor ID#: 788-42925

United States Bankruptcy Court
 Southern District of Texas
 FILED

JUL 20 2000

Michael N. Milby, Clerk

Name of Creditor (The person or other entity to whom the debtor owes money or property):

McAllen Bone & Joint Clinic

Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

Name and address where notices should be sent:

*****AUTO**3-DIGIT 785
 McAllen Bone & Joint Clinic
 1421 N 2nd St Ste C
 McAllen TX 78501-2305

Check box if you have never received any notices from the bankruptcy court in this case

Check box if the address differs from the address on the envelope sent to you by the court.

Account or other number by which creditor identifies debtor:

Check here ☐ replaces if this claim ☐ amends a previously filed claim, dated: _____

1. Basis for Claim

☐ Goods sold
☒ Services performed *Re: Reynaldo Reyna*
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
☐ Other _____

Retiree benefits as defined in 11 U.S.C. § 1114(a)
 Wages, salaries, and compensation (Fill out below)

Your SS#: _____

Unpaid compensation for services performed
 from _____ (date) to _____ (date)

2. Date debt was incurred:

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: \$ 155.01

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.

☐ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:

☐ Real Estate ☐ Motor Vehicle
☐ Other All personal and intangible property of Debtor's Estate

Value of Collateral: \$ _____

Amount of arrearage and other charges at time case filed included in secured claim, if any \$ _____

6. Unsecured Priority Claim.

Check this box if you have an unsecured priority claim

Amount entitled to priority \$ _____

Specify the priority of the claim:

Wages, salaries, or commissions (up to \$4,300),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)

Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).

Up to \$1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).

Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).

Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).

Other - Specify applicable paragraph of 11 U.S.C. § 507(a-____).

*Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

7. Credits: - The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space Is for Court Use Only

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Date

7-17-00

Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):

Miguel A. Hernandez MD

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

WC STAGE STORES
10201 MAIN ST

0008

HOUSTON

TX 77025

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 452271747	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REYNA REYNALDO		3. PATIENT'S BIRTH DATE MM DD YY 02 03 63 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1806 LAUREL OAK WAY CITY EDINBURG STATE TX ZIP CODE 78539 TELEPHONE (Include Area Code) (956) 383 4661		4. INSURED'S NAME (Last Name, First Name, Middle Initial) REBEALL'S 7. INSURED'S ADDRESS (No., Street) 2200 S 10TH CITY MCALLEN STATE TX ZIP CODE 78501 TELEPHONE (INCLUDE AREA CODE) (956) 682 8393	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) WC STAGE STORES		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER 452271747	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME 10201 MAIN ST		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME HOUSTON TX 77025		c. INSURANCE PLAN NAME OR PROGRAM NAME	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE

070300

SIGNED

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: <input checked="" type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 02 08 00		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY N/A	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE GARZA MD BEN		17a. I.D. NUMBER OF REFERRING PHYSICIAN C16010	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 836 0 3. 2. 4. 24. A B C D E F G H I J K DATE(S) OF SERVICE To From MM DD YY MM DD YY Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPST Family Plan EMG COB RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER			

DATE(S) OF SERVICE To From MM DD YY MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
06 30 00 06 30 00	11	1	99024	1	0 01 01					
06 30 00 06 30 00	11	2	20610 RT	1	125 00 01					
06 30 00 06 30 00	11	1	J2000 RT	1	15 00 01					
05 30 00 06 30 00	11	1	J1030	1	15 00 01					

25. FEDERAL TAX I.D. NUMBER 74-2667281		26. PATIENT'S ACCOUNT NO. 144531		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 155 01		29. AMOUNT PAID \$		30. BALANCE DUE \$ 155 01	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse of this bill and are made a part thereof.) MIGUEL A HERNANDEZ MD SIGNED 070300 DATE				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) MCALLEN BONE & JOINT CLINIC, 1421 A NORTH 2ND ST MCALLEN TX 78501 PIN# J3494 GRP#				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE MCALLEN BONE & JOINT CLINIC, 1421 A NORTH 2ND ST MCALLEN TX 78501 PIN# J3494 GRP#			

1 (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

Mfd. by Medical Arts Press
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PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500
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